House of Representatives

General Assembly

File No. 55

February Session, 2004

House Bill No. 5205

House of Representatives, March 15, 2004

The Committee on Insurance and Real Estate reported through REP. OREFICE of the 37th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT ESTABLISHING STANDARDS FOR CONTRACTS BETWEEN MANAGED CARE ORGANIZATIONS AND PHYSICIANS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2004*) (a) As used in this section "contracting health organization" means (1) a managed care organization, as defined in section 38a-478 of the general statutes, as amended; (2) a preferred provider network, as defined in section 38a-479aa of the general statutes, as amended; or (3) any organization operating a workers' compensation insurance arrangement, including, but not limited to, a medical care plan established pursuant to subsection (c) of section 31-279 of the general statutes.

(b) Each contract for services to be provided to residents of this state entered into, renewed, extended, amended or modified on or after October 1, 2004, between a contracting health organization and a physician shall include provisions that: (1) Provide an explanation of the physician payment methodology, the time periods for physician

payments, the information to be relied upon to calculate payments and adjustments and the process to be employed to resolve disputes concerning physician payments; and (2) require that the contracting health organization provide to each participating physician a copy of the fee schedule that determines the physician's reimbursement.

(c) No contract for services to be provided to residents of this state entered into, renewed, extended, amended or modified on or after October 1, 2004, between a contracting health organization and a physician shall include any provision that (1) allows the contracting health organization to unilaterally change any term or provision of the contract, including, but not limited to, fee schedules, provider panels, justification and the opportunity for appeal by the physician or any right of the physician to discuss and negotiate the terms of any contract or the opportunity for the physician to terminate a contract before any amendment becomes effective, except that if the physician chooses to terminate the contract before such amendment becomes effective, such amendment shall not be binding on the physician during any period the physician's obligations continue under the contract, (2) allows the contracting health organization to reduce the level of service coded on a claim submitted by a physician without conducting a reasonable investigation based on all available medical records pertaining to the claim, or (3) delays payment beyond forty-five days after a claim is filed.

(d) Each contracting health organization shall disclose, in writing, upon entering into, renewing, extending, amending or modifying a contract with a physician on or after October 1, 2004, for services to be provided to residents of this state, whether the list of contracted providers and their contracted reimbursement rates may be sold, leased, transferred or disclosed to other payers or other contracting agents, and shall specify whether those payers or contracting agents include workers' compensation insurers or automobile insurers. Each contracting health organization shall, with respect to any contract with a physician in effect on or after October 1, 2004, provide written notice to such physician if the list of contracted providers and their

contracted reimbursement rates may be sold, leased, transferred or disclosed to other payers or other contracting agents, and specify whether those payers or contracting agents include workers' compensation insurers or automobile insurers.

(e) Each contracting health organization shall allow physicians, upon the initial signing, renewal or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred or otherwise disclosed to other payers or contracting agents. If a physician who has elected to be excluded from such a list is included in a list of contracted providers that is sold, leased, transferred or otherwise disclosed to other payers or contracting agents, each physician's election under this subsection shall be binding on each contracting agent or payer that buys, leases or otherwise obtains such list of contracted providers.

(f) No contracting health organization shall intentionally misrepresent to a physician that the contracting health organization is entitled to a certain preferred provider discount or other discount off the fees charged for medical services, procedures or supplies provided by the physician.

(g) No person having knowledge that a contracting health organization intends to make or has made the type of misrepresentations prohibited by subsection (f) of this section shall assist that contracting health organization in obtaining such discount. Any person having knowledge of such misrepresentation prohibited by subsection (f) of this section shall disclose such information to the Insurance Department and the physician to whom a misrepresentation intends to be, or has been, made.

(h) Each contracting health organization shall adhere to the guidelines set forth in the most recent edition of the American Medical Association's Current Procedural Terminology Manual.

Sec. 2. Section 38a-816 of the general statutes is amended by adding subdivision (22) as follows (*Effective October 1, 2004*):

(NEW) (22) Any violation of section 1 of this act.

This act shall take effect as follows:	
Section 1	*October 1, 2004*
Sec. 2	*October 1, 2004*

INS *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 05 $	FY 06 $
Insurance Dept.	IF - None	None	None

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill establishes standards for contracts between managed care organizations, preferred provider networks, or organizations operating workers' compensation insurance arrangements, including medical care plans and physicians contracting with such entities. There is no impact on the Department of Insurance.

OLR BILL ANALYSIS
HB 5205

AN ACT ESTABLISHING STANDARDS FOR CONTRACTS BETWEEN MANAGED CARE ORGANIZATIONS AND PHYSICIANS

SUMMARY:
This bill establishes standards for contracts between physicians and managed care organizations and other contracting health organizes (CHOs). These standards specify what must be included and what may not be included in a contract. The bill also requires CHOs to disclose certain information. The bill applies to contracts for services to be provided to residents of this state entered into, renewed, extended, amended or modified on or after October 1, 2004.

The bill requires each CHO to allow physicians, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or otherwise disclosed to other payers or contracting agents. If a physician who has elected to be excluded from such a list is nevertheless included, his choice to be excluded is binding on each contracting agent or payer that buys, leases, or otherwise obtains such list.

The bill prohibits a CHO from intentionally misrepresenting to a physician that it is entitled to a certain preferred provider discount or other discount off the fees charged for medical services, procedures, or supplies provided by the physician.

The bill also prohibits anyone who knows that a CHO intends to make, or has made, such a misrepresentation from assisting it to obtain such a discount. Anyone who knows of the misrepresentation must disclose it to the Insurance Department and the physician to whom a misrepresentation intends to be, or has been, made.

The bill requires each CHO to adhere to the guidelines in the most recent edition of the American Medical Association's Current Procedural Terminology Manual.

Finally, the bill makes it an unfair method of competition and unfair

and deceptive act or practice in the insurance business to violate any of the bill's requirements or prohibitions. It thereby gives the insurance commissioner the authority to investigate and punish violators.

EFFECTIVE DATE: October 1, 2004

CONTRACTING HEALTH ORGANIZATIONS (CHO)

A "contracting health organization" (CHO) is a (1) a managed care organization; (2) a preferred provider network; or (3) any organization operating a workers' compensation insurance arrangement, including a medical care plan.

A "managed care organization" is an insurer, health care center, hospital or medical service corporation, or other organization delivering, issuing for delivery, renewing, or amending any individual or group health managed care plan in this state.

A "preferred provider network" is an arrangement in which agreements relating to the health care services to be rendered by providers, including the amounts to be paid to the providers for the services, are entered into between the providers and a person who establishes, operates, maintains, or underwrites the arrangement, in whole or in part. It includes any provider-sponsored, preferred-provider network or independent practice association that offers network services. It does not include a workers' compensation preferred-provider organization established under state law or an arrangement relating only to health care services offered by providers to individuals covered under self-insured employee welfare benefit plans established under federal law.

CONTRACT STANDARDS

Required Provisions

The bill requires that contracts must: (1) explain the physician payment methodology, the time periods for physician payments, the information to be relied upon to calculate payments and adjustments, and the process to be employed to resolve disputes concerning physician payments; and (2) require that the CHO provide to each participating physician a copy of the fee schedule that determines the physician's reimbursement.

Prohibited Provisions

The bill prohibits provisions that (1) allow the CHO to unilaterally change any term or provision, including (a) fee schedules, (b) provider panels, (c) justification and the opportunity for appeal by the physician, (d) any right of the physician to discuss and negotiate the terms of any contract, or (e) the opportunity for the physician to terminate a contract before any amendment becomes effective, except that if the physician chooses to terminate the contract before the amendment becomes effective, the amendment is not binding on the physician during any period the physician's obligations continue under the contract, (2) allow the CHO to reduce the level of service coded on a claim submitted by a physician without conducting a reasonable investigation based on all available medical records pertaining to the claim, or (3) delay payment beyond 45 days after a claim is filed.

REQUIRED DISCLOSURES

The bill requires each CHO to disclose, in writing, whether the list of contracted providers and their contracted reimbursement rates may be sold, leased, transferred, or disclosed to other payers or other contracting agents. It requires that the notice specify whether those payers or contracting agents include workers' compensation insurers or automobile insurers. The requirement applies to contracts with physicians in existence on October 1, 2004 and to contracts entered into, amended, renewed, or modified on or after that date.

BACKGROUND

American Medical Association's Current Procedural Terminology Manual

Current Procedural Terminology (CPT) codes are used for reporting medical services and procedures performed by physicians. Their purpose is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, thereby providing an effective means for reliable nationwide communication among physicians, patients, and third parties. This system of terminology is a widely accepted nomenclature for the reporting of physician procedures and services under government and private health

insurance programs.

Unfair Methods of Competition or Unfair or Deceptive Acts or Practices

If, after a hearing, the insurance commissioner determines that a person or entity has engaged in an unfair method of competition or an unfair or deceptive act or practice, he may issue a cease and desist order; order payment of a monetary penalty of up to $1,000 for each violator up to an aggregate of $10,000 in any six-month period, or if the violator knew, or reasonably should have known he was violating the law, a penalty of up to $5,000 per violation up to an aggregate of $50,000 in any six-month period; suspend or revoke the person's or entity's license; or order the violator to pay restitution of any sum obtained because of the violation.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Report
Yea 12 Nay 6